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| Case Number: | CM14-0169563 | | |
| Date Assigned: | 10/17/2014 | Date of Injury: | 01/08/2007 |
| Decision Date: | 01/23/2015 | UR Denial Date: | 10/08/2014 |
| Priority: | Standard | Application Received: | 10/14/2014 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Practice, and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The members DOI is listed as 1/8/2007 but it appears that it represents a so-called industrial continuous trauma injury sustained from 1975 to the indicated DOI in the performance of his duties with a waste disposal company driving trucks and loading/unloading dumpsters. He described his duties as regularly requiring lifting 100 lbs as well as frequent to continuous simple/strong gripping and grasping actions as well as twisting/bending of the neck and back. He additionally was engaged in pushing/pulling and intermittent climbing/stooping and overhead reaching. The member reported a direct injury while on duty moving a filled dumpster up an incline sustaining an injury to his R knee with a "cracking" sensation that he pushed through. He received an evaluation and cares for that specific injury and eventually received arthroscopic surgery that did not relieve the problem. He reports that he experienced developing problems with his L knee attempting to compensate for the R that he did not discuss with the surgeon. During the course of his implement he reports experiencing increasing problems with bilateral knee pain, neck, shoulder, wrists, hands and back pain which he attributed to the nature of his work and did not formally report to his employer at that time. The member had been referred for a comprehensive pain management consultation and report with a DOE 8/20/14. This examination resulted in a request for the use of Transforaminal Epidural Steroid injections that were approved as well as a one month trial of Interferential Stimulation that was non-certified. This review is based on an appeal of this non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Interferential unit rental for 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 114, 118 and 120.

Decision rationale: Transcutaneous electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy, the earliest of which was TENS which remains the most common modality. Interferential Current Stimulation (ICS) uses paired electrodes and two independent circuits carry differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. The frequency allows the Interferential wave to meet low impedance when crossing the skin. The use of two pairs of electrodes allows variation in waveform, stimulus frequency and amplitude or intensity, and the currents rise and fall at different frequencies. It is theorized that the low frequency of the interferential current causes inhibition or habituation of the nervous system, which results in muscle relaxation, suppression of pain and acceleration of healing. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no standardized protocols for the use of interferential therapy and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Two randomized double-blind controlled trials suggested that ICS was effective in alleviating pain and disability in patients with chronic low back pain compared to placebo at 14 weeks, but not at 2 weeks. It has been postulated that Interferential stimulation allows for deeper penetration of tissue. Interferential current is proposed to produce less impedance in the tissue and the intensity provided is suggested to be perceived as more comfortable. Because there is minimal skin resistance with the interferential current therapy, a maximum amount of energy goes deeper into the tissue. It also crisscrosses and this crisscrossing is postulated to be more effective because it serves to confuse the nerve endings, preventing the treated area from adjusting to the current. While not recommended as an isolated intervention, if Interferential stimulation is to be used anyway, it is possibly appropriate if the member has been found to be unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If that is the case then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this particular situation the provider has received permission for a trial of Epidural Steroids. With that in mind the member will not have been shown to be unresponsive to conservative measures. The UR non-certification for a one month trial is supported. Assuming that the member does not respond to the ESI and has indeed persisted with symptoms despite conservative measures a one month efficacy trial could be considered at that time. As such, this request is not medically necessary.